ACCESS REQUEST

Purpose: This form is used for an individual's request to inspect and/or obtain copies of the individual's protected health information or records in our designated record sets or the designated record sets of our business associates.

Please type or print neatly; we are not able to process incomplete or illegible forms.

MDH PROGRAM NAME: _____

SECTION A: Individual requesting access.

Last Name:_____First Name:_____MI: _____

Street Address: _____Apt #: _____ _

City:_____State:_____Zip: _____

Phone: (home)_____(work) _____

Date of Birth: ____/____/____

SECTION B: To the Individual – Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your protected health information in designated record sets maintained by us or our business associates.

Please specify the records you wish to inspect or obtain copies of:

Do you wish to: Inspect these records?_____Obtain copies of these records? _____

We will charge you $ per page to copy these records.

In what form or format (e.g., paper or electronic) would you like us to make the records available to you?

Do you want us to mail the copies? Yes ____No____ Do you want to pick up the copies? Yes ___No ___

We will charge you for postage if mailed.

Please list the name and address of each person, including yourself or your personal representative, for whom you want us to make copies. If you want us to provide access to or copies of our records to any person other than you or your personal representative, you must provide us with a signed authorization. We will supply you with the appropriate authorization form upon request.

SIGNATURE: _____Date: _____

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____